MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: () HCP (x) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address The Hartford P.O. Box 4996 Syracuse, NY 13221	MDR Tracking No.: M4-04-3072-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Arkansas Pioneer Chiropractic P.O. Box 171258 Arlington, TX 76013	Date of Injury: Employer's Name: Lear Corporation Insurance Carrier's No.: YBU 35440

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/16/03	04/16/03	64999-22	$500.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 10/27/03 states in part, "…We would like to request a medical dispute resolution regarding a request for refund from Arkansas – Pioneer Chiropractic. On 5/10/03 a payment was made in the amount of $500.00 to the provider. The provider submitted 64999 22 @$250.00 each. This was paid in full. After reviewing the file we found that this was paid in error, as the documentation indicated that the listed service does not meet the criteria identified in the Fee Guideline Ground Rules and/or code description for reimbursement…"

PART IV: RESPONDENT'S POSITION SUMMARY

No response submitted.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

According to the Overpayment Letter Referral Form submitted by the Requestor the first request for refund to the Respondent was 06/12/03. The submitted EOB was date stamped 04/24/03; therefore, per Rule 133.304(a) and (b)(3) the Requestor did not request the refund within the 45th day after the Requestor received a complete medical bill. Refund Reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to refund reimbursement.

Ordered by:

	Marguerite Foster	02/17/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____